SECTION C

Role of the State of Rhode Island

What must be recognized about the Rhode Island program is that it is neither an effort by government to arbitrarily impose rates or budgets on hospitals, nor an attempt by the voluntary sector (Blue Cross of Rhode Island and hospitals) to operate a cost containment program outside of the aegis of the government sector. Rather, it is an attempt to fashion a true partnership between the government and voluntary sectors in an effort to foster more cost conscious and effective hospital operations. The program does not provide for hospitals to operate on rates unilaterally established as a result of a State Rate Setting process. However, by State Law, no hospital's budget can be negotiated without the direct participation and concurrence of the State Budget Officer or his representative.

The impetus for the program can be traced to a 1969 decision of the State's Director of Business Regulation. Disenchanted with the then prevailing cost reimbursement formula, and its deleterious impact on the hospital cost spiral, the Director encouraged the voluntary sector to revamp the reimbursement system. Thus, the initial prospective rating efforts in the state, while sparked by a high ranking state official were voluntary in the sense that continuance of the cost reimbursement formula would not have violated state law. However, in 1971 the Rhode Island General Assembly passed specific legislation requiring the State Budget Officer to be an active participant in the prospective budget negotiations between voluntary hospitals and major third party purchasers (Blue Cross). The Budget Officer, or his designee would actively engage in the analysis and negotiation of hospital budgets for the purpose of establishing rates for the State and Blue Cross.

Since the enactment of the legislation, the State Budget Office has played a major role in shaping the program, and no portion of the current program (designed in 1974) has been implemented without the express approval of the State. As third party purchasers, Blue Cross and the State Budget Office must jointly agree to a negotiating position before it is presented to a hospital. In fact, the contract clearly stipulates that it is designed to comply with State law.

Program Administration

One of the positive features of the current program design is that it does not require the commitment of massive government resources to accomplish the goal of hospital cost control. Administrative responsibility for many facets of the program are shared by Blue Cross and the State. However, each organization is administratively responsible for establishing the rates for their own programs, monitoring the financial impact of the negotiated budgets on the programs, and effective year end settlements to bring actual payments into line with program commitments. Shared responsibilities include the negotiation and analysis of budgets, the application of basic cost finding techniques to the negotiated budget, the monitoring of financial results under the program, and of course the negotiation of basic contract issues.

Specifically, the program is administered as follows:

1. In March of each year the State Budget Office and Blue Cross of Rhode Island begin to discuss strategy for Maxicap negotiations. Throughout the year, staff of both Blue Cross and the State Budget Office collect data pertinent to these negotiations. During February and March of each year the amount of staff time invested in this activity increases considerably.

In that both the State Budget Office and Blue Cross must mutually agree on a position and strategy prior to presenting this view to the hospitals, caucuses are arranged prior to the actual negotiations with the hospital.

Of course, during the same time frame, the hospitals through the Hospital Association of Rhode Island are busy constructing their own negotiating position.

2. During April, the actual negotiation of the Maxicap takes place. From the standpoint of the purchasers of care, State Budget Office and Blue Cross staff interface for all the developmental and analytical work associated with their negotiating positions. The Hospital Association of Rhode Island coordinates all the work associated with the hospital's position.

3. Once the Maxicap is finalized, either through negotiations or arbitration if necessary, a jointly agreed to (Blue Cross, State Budget Office, Hospital Association of Rhode Island) budget package is forwarded to each of the hospitals participating in the program. Each hospital is required to complete such packages in total, and these packages become the key document on which the negotiation of individual hospital budgets takes place.

Each package is carefully analyzed by a combined staff of Blue Cross and State Budget Office analysts prior to the time that any negotiating strategy is developed.

4. After budget packages are submitted, and all the analysis is completed, negotiation of individual budgets takes place. Representatives from the State Budget Office, Blue Cross of Rhode Island, and the Hospital must be present in order for negotiations to proceed. The State Budget Officer, or his designee must participate in these negotiations in order to satisfy Chapter 27, Title 14 (S-162A) of the State Laws.

5. If a Budget is successfully negotiated, then the individual third party purchasers (Blue Cross and the State) become responsible for establishing the resulting rates specifically for their programs. State Budget Office personnel are responsible for calculating the State rates (Title 19, Title 5 and other participating State programs) in conjunction with the appropriate State agencies. Obviously, the preponderance of state business is related to Title 19 business, and in this respect the State Budget Office must coordinate the establishment of applicable State Rates with the Department of Social and Rehabilitative Services (SRS) which is responsible for the State's Medicaid Program. Actual implementation of the State Title 19 rates must take place through the State Medicaid Program, as follows:

Section 405.455(a) (HIRM-1):

Amount of Payment Where Customary Charges for Services Furnished are Less than Reasonable Cost.

"Providers of services will be paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges made by the provider of the same services."

Under the Prospective Reimbursement Program in Rhode Island, a pro-

spective RCC test for Medicaid is done on total hospital activity prior to the start of a fiscal year for allowable medicaid costs and charges related to programs reimbursable under the medicaid program. In all situations where prospectively determined costs for allowable programs exceed budgeted charges, the hospitals R.C.C. will not exceed 100% for both the inpatient and outpatient portions of the business. However, if a hospital demonstrates that in the aggregate charges for reimbursable programs exceed the medicaid allowable costs, then on the R.C.C.'s could exceed 100% (e.g. an outpatient R.C.C. of 102%, as long as the inpatient R.C.C. is sufficiently low, e.g. 90%), so that in the aggregate the hospital can pass this prospective test. At no time will the outpatient basis of reimbursement exceed the Title XVIII upper limits.

6. If a budget cannot be settled at the negotiating table, it must be referred to a mediation/arbitration process. This process is basically the same whether it is invoked relative to individual budgets of MAXICAP. Mediation is a non-binding process where the issues can be aired before high level representatives of the various parties. The mediation process takes place before a panel of 12 mediators. Six of the mediators represent the hospitals, and six the third party purchasers. Two of the six third party representatives must be high ranking state officials.

The mediation panel is only empowered to recommend a decision. If they are unable to reach such a decision, or their decision is unacceptable to either the hospital or third parties, the budget must be referred to Binding Arbitration. Arbitration takes place before a three man panel. The State

Budget Office and Blue Cross jointly select an arbitrator, the hospital selects one, and these two arbitrators select a neutral third.

Relationship Between the State Budget Office and the State Medicaid Agency

In view of the fact that the State Budget Office plays a leading role in establishing rates that are paid by the Title 19 Medicaid Program, it is imperative that a close working relationship between the State Budget Office and the Department of Social and Rehabilitative Services (SRS) be maintained. Since traditionally, both agencies have worked closely, particularly in areas that effect the financing of the State Medicaid Program, the agencies have been able to develop a strong working relationship. As the Department of SRS is administratively responsible for operation of the Title 19 program, they are keenly concerned with the rapid rise in the costs of hospitalization. The State Budget Office legislatively injected into a program designed to control hospital costs must identify closely with the Title 19 agency if their efforts are to be successful. It is fair to say that the positions with respect to the program, as espoused by the State Budget Office at the table, must in the final analysis have the support of the Title 19 agency. In fact, frequent interface between the staffs of the agencies must occur, and both agencies must keep apprised of the latest developments relative to the program.

In summary, the State Budget Office represents in concept the State of Rhode Island at the negotiating table. Title 19 as the largest purchaser of care plays a key role in influencing and shaping the positions taken by the Budget Office at the negotiating table.

Single State Agency:

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1. Compliance with Appropriate Federal Regulations -

The Single State Agency will oversee the activities of the State Budget Office in the implementation of this program and will insure full compliance with 45 CFR 205.100.

2. Criteria For Approval of A Plan -

The Single State Agency will ensure that the plan will include the necessary criteria described under Title 45, Public Welfare, Section 250.30 as follows:

a. "Incentives for efficiency and economy." - The following are basic features of the program:

1) MAXICAP

One of the most creative aspects to the Rhode Island program is a negotiated prospective limitation on the total operating expense increases for all hospitals in the state. This limitation is called a MAXICAP, and represents an outside limitation within which all hospital budgets must be negotiated. While individual budgets may be settled above or below the MAXICAP in the aggregate the total settlements must not exceed the MAXICAP. The MAXICAP incorporates all expense categories, including salaries and wages, supplied and expenses, new program development, and volume.

2) Prospective Budgeting

All hospitals in the state are required to negotiate total operating expense budgets in advance of the fiscal year with the Third

Parties. Each hospital is required to submit a detailed budget package for analysis by the Third Party purchasers (Blue Cross and the State). Rates are established based on the negotiated budget and statistics.

3) Program Planning

The reimbursement process is heavily linked to the planning process, and all new medical programs that exceed predetermined dollar criteria must be channeled through this process prior to consideration at the negotiating table. The planning process ranks these programs in order of priority.

4) Volume

Three separate volume corridors (Inpatient Routine, Inpatient Ancillary and Outpatient) are included in the program. As actual volume varies from budgeted volume, automatic adjustments in the hospitals budgeted revenue are made. The corridors are designed so that an institution will be reimbursed for increased or decreased volume in relation to fixed costs when activity is decreasing and variable costs when activity is increasing. The idea is that hospitals should not profit from high volume or be penalized because of low volume.

b. "Reimbursement on a reasonable cost basis." - The program will continue following Medicare/Medicaid principles of reimbursement. The only change is that reimbursement will be prospective rather than retrospective.

c. "Reimbursement not to exceed that which would be produced through the application of the Title XVIII standard and principles of reimbursement." - The criteria which would be applied on a prospective rather than a retrospective basis.

d. "Assurance of adequate participation of hospitals and availability of hospital services of high quality to Title XIX recipients." - A letter of intent has been received from the Hospital Association of Rhode Island as agent for all Rhode Island voluntary hospitals indicating their willingness to participate in the prospective reimbursement program for the period from October 1, 1979 through September 30, 1980.

e. "Adequate documentation for evaluation of experience under the State's approved reimbursement plan." See Section A - Part II.

f. The regulations also note that "State Title XIX agencies are encouraged to involve representative provider organizations in the development of such plans." As noted earlier, the Hospital Association of Rhode Island, representing all the hospitals in Rhode Island, was an active participant in the development of the prospective reimbursement program, and will continue to participate as before.

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State Rhode Island

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Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

Section D

Plan Amendment: Administratively Necessary Days Coverage

A. Scope of Coverage and Payment

1. Covered Patients

Payment for Administratively Necessary Days (AND) for Medical Assistance recipients with Medicare coverage (dual enrollees) awaiting alternate care placement will begin on the day beyond the second day following the date of the notice that hospital level of care is no longer medically necessary.(1) For example, if a notice is given to the patient on Monday, the first AND for which payment will be made is Thursday. Payment for AND's for Medical Assistance recipients without Medicare coverage will begin on the day following the day of notice that hospital level of care is no longer medically necessary. For example, if a notice is given to the patient on Monday, AND payment will begin on Tuesday. Administratively Necessary Days beyond 25 will be considered for reimbursement on the basis of prior authorization.

2. Payment Amounts

Payment for all days of AND status after the above notification periods shall be made at:

(1) 60% of the hospital's prospective routine costs (excluding ICU costs and days from such calculation) and (2) all ancillary services subject to applicable prospective RCC rate.

(1) This is per Section 405.472 of Medicare Regulations which defines beneficiary liability.